REPORT - HIPAA 835 to AFRS Batch I/F mapped fields only

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
		Health Care Claim Payment/Advice						A19 to AFRS for payment. Need to store fields from the 837-claim to populate the 835-RA.	Processing Logic
	ST	**Transaction Set Header**		**R**					
	ST 01	Transaction Set Identifier Code	ID3	R				Hard code "835"	Translation
	ST 02	Transaction Set Control Number	AN9	R				Compute; Generate from 1 increment by 1 for each TS in a functional group	Translation
	BPR	**Financial Information**		**R**				BALANCING: (sum of all CLP04-claim payments) minus (sum of PLB prov adj) must equal BPR02-payment amount	Processing Logic
	BPR01	Transaction Handling Code	ID2	R				Hard code; "P"=pre-notify to test; else "I"	Translation
	BPR02	Total Actual Provider Payment Amount	R18	R	AFRS-batch-trans	TRANS-AMT		If multiple providers or claims in this transaction, this is sum of all payments for this transaction.	Translation
	BPR03	Credit or Debit Flag Code	ID1	R				Hard code "C	Translation
	BPR04	Payment Method Code	ID3	R				If by check, use "CHK"; if info. only, use "NON"; if EFT, use "ACH"	Translation
	BPR05	Payment Format Code	ID10	S				Use BPR05+ only if doing EFT (BPR04="ACH")	Translation
	BPR06	Depository Financial Institution (DFI) Identification Number Qualifier	ID2	S				Hard code "01" for US banks	Translation
	BPR07	Sender DFI Identifier	AN12	S				Hard code payor's BankID	Translation
	BPR08	Account Number Qualifier	ID3	S				Hard code "DA"	Translation

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
	BPR09	Sender Bank Account Number	AN35	S				Hard code payor's Account Number	Translation
	BPR10	Payer Identifier	AN10	S				Hard code "1"+payor's Fed TaxID	Translation
	BPR12	Depository Financial Institution (DFI) Identification Number Qualifier	ID2	S				Hard code "01" for US banks	Translation
	BPR13	Receiver or Provider Bank ID Number	AN12	S	AFRS-batch-trans	DFI-ROUTING-NUMBER			
	BPR14	Account Number Qualifier	ID3	S	AFRS-batch-trans	ACCOUNT-TYPE		if "C", use "DA"; if "S", use "SG"	Translation
	BPR15	Receiver or Provider Account Number	AN35	S	AFRS-batch-trans	DFI-ACCOUNT-NUMBER			
	BPR16	Check Issue or EFT Effective Date	DT8	R	AFRS-batch-trans	WARRANT-ISSUE-DATE			
	TRN	**Reassociation Trace Number**		**R**				Need to store ACH ID number (warrant number)	HIPAA Required
	TRN01	Trace Type Code	ID2	R				Hard code "1"	Translation
	TRN02	Check or EFT Trace Number	AN30	R	AFRS-batch-trans	WARRANT-NUMBER		If BPR04="NON" generate unique ID across all remittance advices; if BPR04="CHK" use check number; if BPR04="EFT" use ACH number	Translation
	TRN03	Payer Identifier	AN10	R				Same as BPR10, in case different payers use the same TRN02 numbers	Translation
	CUR	**Foreign Currency Information**		**S**					
	REF	**Receiver Identification**		**S**				Req'd if 835 sent to anyone other than payee	HIPAA Required
	REF01	Reference Identification Qualifier	ID3	R				"EV"-receiver ID	Translation

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
	REF02	Receiver Identifier	AN30	R				Get from 837 NM109-Submitter Identifier	Match Back
	REF	**Version Identification**		S					
	REF01	Reference Identification Qualifier	ID3	R				Hard code "F2"	Translation
	REF02	Version Identification Code	AN30	R				Hard code; version number of TARGET system	Translation
	DTM	**Production Date**		S					
1000A	*N 1*	*Payer Identification*		*R*					
1000A	**N 1**	**Payer Identification**		**R**					
1000A	N 101	Entity Identifier Code	ID3	R				Hard code "PR"	Translation
1000A	N 102	Payer Name	AN60	S				Hard code payor's name: "WA DSHS DASA"	Translation
1000A	N 103	Identification Code Qualifier	ID2	S				Hard code "XV" when PlanID used; else "FI"-federal tax ID	Translation
1000A	N 104	Payer Identifier	AN80	S	AFRS-batch-trans	ORG		Hard code payor's National PlanID when used; else federal tax ID	Map Codes
1000A	**N 3**	**Payer Address**		**R**					
1000A	N 301	Payer Address Line	AN55	R				Hard code payor's address	Translation
1000A	**N 4**	**Payer City, State, ZIP Code**		**R**					
1000A	N 401	Payer City Name	AN30	R				Hard code payor's address	Translation
1000A	N 402	Payer State Code	ID2	R				Hard code payor's address	Translation
1000A	N 403	Payer Postal Zone or ZIP Code	ID15	R				Hard code payor's address	Translation
1000A	**REF**	**Additional Payer Identification**		**S**					

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
1000A	PER	**Payer Contact Information**		S					
1000A	PER01	Contact Function Code	ID2	R				Hard code "CX"	Translation
1000A	PER02	Payer Contact Name	AN60	S				Hard code payor's adjudication contact for electronic remittance advice	Translation
1000A	PER04	Payer Contact Communication Number	AN80	S				Hard code contact phone #	Translation
1000B	*N 1*	*Payee Identification*		*R*					
1000B	N 1	**Payee Identification**		R					
1000B	N 101	Entity Identifier Code	ID3	R				Hard code "PE"	Translation
1000B	N 102	Payee Name	AN60	S	AFRS-batch-trans	VENDOR-NAME			
1000B	N 103	Identification Code Qualifier	ID2	R				Hard code "F1"-TaxID, until NPI used.	Translation
1000B	N 104	Payee Identification Code	AN80	R	AFRS-batch-trans	TAXPAYER-ID-NO		If prov is person, use SSN, else use emplr-num	Translation
1000B	N 104	Payee Identification Code	AN80	R	AFRS-batch-trans	VENDOR-NO		If prov is person, use SSN, else use emplr-num	Translation
1000B	N 3	**Payee Address**		S					
1000B	N 301	Payee Address Line	AN55	R	AFRS-batch-trans	VENDOR-ADDR-1			
1000B	N 302	Payee Address Line	AN55	S	AFRS-batch-trans	VENDOR-ADDR-3			
1000B	N 4	**Payee City, State, ZIP Code**		S					
1000B	N 401	Payee City Name	AN30	R	AFRS-batch-trans	VENDOR-CITY			

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
1000B	N 402	Payee State Code	ID2	R	AFRS-batch-trans	VENDOR-STATE			
1000B	N 403	Payee Postal Zone or ZIP Code	ID15	R	AFRS-batch-trans	VENDOR-ZIP			
1000B	**REF**	**Payee Additional Identification**		**S**					
1000B	REF01	Reference Identification Qualifier	ID3	R				hard code "PQ"-local ID for payee	Translation
2000	*LX*	*Header Number*		*S*					
2000	**LX**	**Header Number**		**S**					
2000	LX 01	Assigned Number	N06	R				Required if > 1 claim per transaction.	System Questions
2000	**TS3**	**Provider Summary Information**		**S**					
2000	TS309	Total Provider Payment Amount	R18	S	AFRS-batch-trans	TRANS-AMT			
2000	**TS2**	**Provider Supplemental Summary Information**		**S**					
2100	*CLP*	*Claim Payment Information*		*R*					
2100	**CLP**	**Claim Payment Information**		**R**				BALANCING: CLP03-claim charge minus (sum of all CAS service line adjustments) must equal CLP04-claim payment	Processing Logic
2100	CLP01	Patient Control Number	AN38	R				Provider's ID for patient, as received on 837-claim CLM01	HIPAA Required
2100	CLP02	Claim Status Code	ID2	R				map codes; default to "3"-processed as tertiary	Map Codes
2100	CLP03	Total Claim Charge Amount	R18	R				required	HIPAA Required

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2100	CLP04	Claim Payment Amount	R18	R	AFRS-batch-trans	TRANS-AMT		required	HIPAA Required
2100	CLP06	Claim Filing Indicator Code	ID2	R				For MHD, hardcode "14"-exclusive provider org.	HIPAA Required
2100	CLP11	Diagnosis Related Group (DRG) Code	ID4	S				Institutional only: required if DRG is used to adjudicate claim	HIPAA Required
2100	CLP12	Diagnosis Related Group (DRG) Weight	R15	S				institutional only, required if DRG is used to adjudicate claim	HIPAA Required
2100	**CAS**	**Claim Adjustment**		**S**					
2100	CAS01	Claim Adjustment Group Code	ID2	R				required if paid amt <> billed amt	Map Codes
2100	CAS02	Adjustment Reason Code	ID5	R				required if paid amt <> billed amt	Map Codes
2100	CAS03	Adjustment Amount	R18	R				required if paid amt <> billed amt	HIPAA Required
2100	CAS04	Adjustment Quantity	R15	S				subtract total claim submitted units (need to store for SVC07) from total claim paid units (units-of-service)	HIPAA Required
2100	**NM1**	**Patient Name**		**R**					
2100	NM101	Entity Identifier Code	ID3	R				Hard code "QC"	Translation
2100	NM102	Entity Type Qualifier	ID1	R				Hard code "1"	Translation
2100	NM103	Patient Last Name	AN35	R				As it came in on 837 Loop 2010BA NM1	HIPAA Required
2100	NM104	Patient First Name	AN25	R				As it came in on 837 Loop 2010BA NM1	HIPAA Required
2100	NM108	Identification Code Qualifier	ID2	S				Hard code "MR"-Medicaid recip ID or "MI"-member ID	Translation
2100	**NM1**	**Insured Name**		**S**					
2100	**NM1**	**Corrected Patient/Insured Name**		**S**				Required if patient name is corrected from 837 to 835	System Questions
2100	NM101	Entity Identifier Code	ID3	R				Hard code "74"	Translation

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2100	NM102	Entity Type Qualifier	ID1	R				Hard code "1"	Translation
2100	NM103	Corrected Patient or Insured Last Name	AN35	S				required if 837 name <> 835 name	HIPAA Required
2100	NM108	Identification Code Qualifier	ID2	S				Hard code "C"-Insured's changed Medicaid recip ID number	Translation
2100	**NM1**	**Service Provider Name**		**S**				required if payee <> service provider	System Questions
2100	NM101	Entity Identifier Code	ID3	R				Hard code "82"-Rendering Provider	Translation
2100	NM103	Rendering Provider Last or Organization Name	AN35	S				required if payee <> service provider	System Questions
2100	NM108	Identification Code Qualifier	ID2	R				Hard code "MC"-Medicaid ID or "XX"-NPII	Translation
2100	**NM1**	**Crossover Carrier Name**		**S**				Any TPL?	System Questions
2100	NM101	Entity Identifier Code	ID3	R				Hard code "TT"=TPL carrier	Translation
2100	**NM1**	**Corrected Priority Payer Name**		**S**				This segment will be populated if this payer should be paying BEFORE Medicaid pays. The segment prior to this one will be populated if that payer pays AFTER Medicaid pays. The logic to determine this would have to be added to the MMIS.	Electronic COB
2100	NM101	Entity Identifier Code	ID3	R				Verify "PR"	Translation
2100	NM102	Entity Type Qualifier	ID1	R				Hard code "2"	Translation
2100	NM108	Identification Code Qualifier	ID2	R				Hard code "PI"-payer ID or "XV"-Nat'l Plan ID	Translation
2100	NM109	Corrected Priority Payer Identification Number	AN80	R				Need to map to standard ID schema.	Map Codes
2100	**MIA**	**Inpatient Adjudication Information**		**S**				This segment is for inpat. inst. only	Translation
2100	**MOA**	**Outpatient Adjudication Information**		**S**				This segment is for all claims except inpat. inst.	Translation

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2100	REF	Other Claim Related Identification		S					
2100	REF01	Reference Identification Qualifier	ID3	R				Send "1W" with recip client ID; send "F8" with tcn-to-credit; send "G1" with prior auth #; send "SY" with SSN	Translation
2100	REF	Rendering Provider Identification		S					
2100	DTM	Claim Date		S				required if not all service lines have dates	System Questions
2100	DTM01	Date Time Qualifier	ID3	R				if range, "232"=Claim Statement Period Start; "233"=Claim Statement Period End; send "050" with date-entered-loc	Translation
2100	PER	Claim Contact Information		S					
2100	AMT	Claim Supplemental Information		S					
2100	AMT01	Amount Qualifier Code	ID3	R				With "AU", send sum of claim's lines' <allowd chrg>; with "F5", send <clm-recip-pmt-amt>; with "T", send tax-amount; with "D8", send sum of adjustment amts where EOB-CODE = <discount>; with "T2", send same as with "AU"	Translation
2100	QTY	Claim Supplemental Information Quantity		S					
2110	*SVC*	*Service Payment Information*		*S*				Support max 999 service lines per claim	HIPAA Required
2110	SVC	Service Payment Information		S				BALANCING: SVC02-submitted service charge minus (the sum of all CAS adjustments) must equal SVC03-service payment	Policy Issues
2110	SVC01	Product or Service ID Qualifier	ID2	R				Store 837 SV101-1, or "NU" for paper UB	Map Codes

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2110	SVC01	Procedure Code	AN48	R				Required if adjudicated at service line level.	HIPAA Required
2110	SVC01	Procedure Modifier	AN2	S				professional only: Store all modifiers from 837 SV101	Match Back
2110	SVC02	Line Item Charge Amount	R18	R				Required if adjudicated at service line level.	System Questions
2110	SVC03	Line Item Provider Payment Amount	R18	R				Required if adjudicated at service line level.	System Questions
2110	SVC07	Original Units of Service Count	R15	S				Used and required only if paid number of units differs from billed number of units; store original units from 837 SV104	System Questions
2110	**DTM**	**Service Date**		**S**				Required if there is no claim date.	System Questions
2110	DTM01	Date Time Qualifier	ID3	R				Hard code; "472" for one date service; "150" for begin of date range; "151" for end of date range	Translation
2110	**CAS**	**Service Adjustment**		**S**				Are there any service level adjustments?	System Questions
2110	CAS01	Claim Adjustment Group Code	ID2	R				Derive group code using logic in I.G., sec 2.2.4 and p. 21, 150.	Map Codes
2110	CAS02	Adjustment Reason Code	ID5	R				Map per EOB TAG	Map Codes
2110	CAS03	Adjustment Amount	R18	R				Must store amounts for all adjustments	HIPAA Required
2110	CAS04	Adjustment Quantity	R15	S				subtract paid units (SVC05) from submitted units (SVC07)	Translation
2110	**REF**	**Service Identification**		**S**				"6R" required if sent on 837.	HIPAA Required
2110	REF01	Reference Identification Qualifier	ID3	R				Hard code; "6R"=Provider's line item number; "G1"=prior authorization number	Translation
2110	REF02	Provider Identifier	AN30	R				we also need PA# at service line level	Processing Logic

Loop	SegID	HIPAA Name	DT	Req	File	Field	DT	Comment	CommentType
2110	**REF**	**Rendering Provider Information**		**S**				We may need to have service provider on each service line level, not just claim level.	Nice to Have
2110	**AMT**	**Service Supplemental Amount**		**S**					
2110	**QTY**	**Service Supplemental Quantity**		**S**					
2110	**LQ**	**Health Care Remark Codes**		**S**				For EOB codes not linked to funds.	System Questions
2110	LQ 01	Code List Qualifier Code	ID3	R				Hard code "HE", claim payment remark code	Translation
2110	LQ 02	Remark Code	AN30	R				map to codes from EOB TAG	Map Codes
2110	**PLB**	**Provider Adjustment**		**S**				Any adjustments not specific to a claim (provider level)?	System Questions
2110	**SE**	**Transaction Set Trailer**		**R**					
2110	SE 01	Transaction Segment Count	N010	R				Compute, number of included segments, including ST, SE	Translation
2110	SE 02	Transaction Set Control Number	AN9	R				Same as ST02	Translation

Comment Type Legend:

Case Management = "Nice to Have" fields for case reviewers.

Electronic COB = If we do electronic COB, these fields will be needed.

HIPAA Questions = Questions about interpreting the HIPAA Implementation Guides.

HIPAA Required = Required fields in HIPAA that don't seem to be in the legacy system.

Map Codes = Need to crosswalk local codes to standard codes.

Match Back = Fields received on an incoming transaction that must be returned in the response.

Nice to Have = Optional fields that are useful for other reasons.

Policy Issues = Decisions to be made by system experts.

Processing Logic = Logic that needs to be built into either the front end or MMIS.

System Questions = Questions about the legacy systems.

Translation = Only use to program translations.

Column Heading Legend:

"DT" = Data Type

COBOL Data Types Legend:

X(n) - Character data with length of n bytes

9(n) - Integer data with length of n bytes

S9(n) - Signed integer data with length of n bytes

9(n)V99 or 9(n)V9(2) - Numeric data with n decimal digits before the decimal point and 2 decimal digits after the decimal point

S9(n)V99 or S9(n)V9(2) - Signed numeric data with n decimal digits before the decimal point and 2 decimal digits after the decimal point

HIPAA Data Types Legend:

ANn - Free text with length of n bytes

IDn - Coded value with length of n bytes

Nn - Numeric data with length of n bytes

Rn - Real data with length of n bytes

DT8 - Date expressed as CCYYMMDD

TM8 - Time expressed as HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds ((00-99)